Recovery Support Services ATR-I
Billing Procedures
Provider Packet List

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Purpose: Business Psychology Associates (BPA) endeavors to serve members and providers by providing accurate and timely payment of submitted claims. To that end it is recognized that both the providers and BPA must consistently comply with certain guidelines.

BPA Guidelines:

- Clean claims* will be paid/denied within 30 calendar days of receipt.
- A *Detailed Remittance Advice* report (Exhibit E) for claims processed will be issued including both paid and denied claims.
- A manual denial will be issued for claims that cannot be entered into the system. The reason for denial (insufficient information, etc) and the original claim will be attached. The claim will not have been "received" for purposes of timeliness nor reconciliation.
- Claims will be paid according to the current *Rate Schedule Matrix* (Exhibit B) unless the billed amount is less than the current *Rate Schedule Matrix*. The lesser of the two amounts will be paid.
- *clean claim – A claim with all required information included. Additionally a claim with all billed services previously authorized.

Providers billing BPA Guidelines:
Note: *Failure to comply with any of the following procedures may result in claim denials.*

Section 1: Client Specific Services

- Non-electronic claims will be accepted in either of two formats. BPA will accept the *HCFA 1500* (Exhibit D) or the *BPA Spreadsheet Format* (Exhibit C).
- All claims **must** be submitted within 60 calendar days of the date of service (DOS).
- Non-electronic claims must be on paper and mailed. Faxed claims will not be accepted nor recognized as having been received.
- Providers must bill using the correct funding source (ie ATR-I, PWWC, etc.).
- Providers must bill using the correct authorization/voucher number.
- Providers must bill using the correct procedure code (Exhibit B)
- Providers must bill using the correct units (Exhibit B).
- Providers must submit certain required fields.
- The billing claim must be legible.
- Providers may resubmit claims, after 30 calendar days from initial submission, if the provider has received no response to the initial submission.
- Providers must clearly mark a resubmitted claim as a resubmission.

Business Psychology Associates Claims Submission Process

Submitting a non-electronic claim for client specific services:

1. Submit claims for authorized, treatment services performed within 60 days of the date of service (DOS).
2. Accurately complete all required fields (included in this packet) on either a HCFA 1500 or the BPA Alternative Billing Form.
3. Follow the instructions for completing the selected form. Instructions for both forms are included in this packet.
4. If you use the HCFA 1500 only one client with multiple services may be submitted per form.
5. If you use the BPA Alternative Billing Form multiple clients with multiple services may be submitted per form. Said form may have multiple pages. This form must be typed or it will not be accepted.
6. Submit the form(s) of your choice in hard copy by mailing them to:

   BPA
   Claims Processing Dept.
   380 E. Parkcenter Blvd.
   Suite 300
   Boise, ID 83706

7. Contractually, the claim line items will be paid or denied within 30 days of the date the claim was received at BPA. As hard-copy claims are received at BPA they are date stamped to ensure an accurate receive date.
8. If a claim has not been paid or denied within the 30 days then the provider may resubmit the claim. The claim must be clearly marked as a resubmission or it may be processed as a new claim which could cause duplication issues. It is helpful if the provider allows for adequate time to receive a remittance advice before re-submitting the claim. **Denied claims should never be resubmitted without due cause.**
9. If a claim has been denied and the provider disagrees with or does not understand the denial, the provider should submit an appeal form, included in this packet. The appeal will be considered and adjudicated within 30 days. This should be mailed to:

   BPA
   Quality Assurance Dept.
   380 E. Parkcenter Blvd.
   Suite 300
   Boise, ID 83706

10. If a provider has an unresolved issue they should mail a complaint form (included in the packet) to the Quality Assurance Dept. at the above address.

Business Psychology Associates

380 Parkcenter Blvd., Suite 300, Boise, Idaho 83706
Toll Free 1-800-922-3406

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Notice of Service Authorization and/or Change in Service Authorization

Tuesday, December 13, 2005

Provider Name and Location Authorized

RSS Service Provider
Support Services Location
Boise, ID 83706
888-888-8888

Authorized Provider Information

Client's ID & Policy Number

Authorized Consumer Name and Address - Client ID: Client ID / Policy Number

SSA Client
Client's Address
Boise, ID 83706
Home Phone: 222-222-2222
Date of Birth: 01/01/1900

Authorized Client Information

Client's Insurer & Reimbursement Rate. REMEMBER: Regardless of what the Reimbursement Rate the Client has, RSS services are paid out at 100%.

Funding Source and Reimbursement Rate: DHW - ATR-I / ATR-I - 95%
Authorization Start Date: 12/1/2005
Expiration Date: 6/1/2006

Authorization Date Span

Authorization Number to be associated with billings.

Level of Care	Authorization #	# of Units
SSA - SupSvc - Case Management	200500065541	40

Authorized Service. Drug Testing, Transportation, etc. would appear depending on the Service Authorized.

Number of Units authorized for this authorization.

This authorization is limited to the above named provider, the service specified, and is not to exceed the units indicated. This authorization is valid until the above stated expiration date. This voucher expires when the date span ends or the number of units is reached, whichever occurs first. This authorization is not a guarantee of payment. Payment is based on the client's eligibility and contract benefits. Payment will be made at provider's contracted rate minus any client co-payments. Provider will submit claims utilizing the Client ID and Voucher Numbers for reference/authentication. This authorization will terminate if the client transfers to a different level of care. The above named date span and authorized units is subject to change, recipient is responsible for updating their records based upon receipt of changed authorizations.

Should this authorization date span and/or authorized units for the above named authorization number be altered in any manner from preceding authorizations, this letter supersedes all other date span and/or units authorized for the identified authorization number.

Should your authorized service on this letter specify Waiting List Placement: This letter is to inform you that you have been screened as eligible for State of Idaho funding for Substance Abuse Treatment. This letter also serves to inform you that you have been added to a waiting list for the above named services. BPA will contact you when services are available to confirm your eligibility and authorize services.

Should you have an emergency while you are waiting for services please go to your local emergency room.

To find local meeting times for AA visit www.idahoarea18aa.org or dial 2-1-1 Idaho Care Line for your local Alcoholics Anonymous chapter. For local NA meetings visit www.theagapecenter.com/NAinUSA/Idaho.htm or dial 2-1-1 Idaho Care Line for your local Narcotics Anonymous Chapter.

Should you have any questions please call BPA at 1-800-922-3406.

Sincerely,
Care Management Staff

Rate Schedule Matrix
Department of Health and Welfare
Recovery Support Services System

***Client Specific Services:** *To be billed on HCFA 1500 or BPA RSS Alternative Billing Form.*

Recovery Support Service	Frequency/Limits	Procedure Code	Unit	Contracted Rate	Yearly Maximum
Case Management		H0006	15 min	$11.25	24 Hours (96 Units)
Drug/Alcohol Testing	Not to exceed 4 tests per month.	H0003	1 Test	$13.50	20 Tests
Family/Marital/Life Skills Education - **Individual**		H2015	15 min	$6.25	60 hours (240 units)
Family/Marital/Life Skills Education - **Group**		HQ2015	15 min	$2.50	
Family/Marital/Life Skills Education – **client not present** **codes with modifier to be used for services provided when client is not present*		H2015.HS HQ2015.HS	15 min	$6.25 $2.50	
Adult Safe & Sober Housing		H0044	1 day	$11.50	1 year (365 Units)
Adolescent Transitional Housing – ***currently not available***		H0043	1 day	$100.00	
Transportation	Maximum of 400 miles in a 3 month period	A0080	1 mile	0.48	1600 Miles
Child Care– ***currently not available***			1 hour	3.85	

***Family/Marital/Educational Life Skills is currently only available to providers who are contracted through DHW to provide Recovery Support Services.

Business Psychology Associates State of Idaho Substance Abuse Contract Recovery Support Services Alternative Billing Form

Facility/Provider: ____ Submission Date: ________________________ Page # _____

BPA Client ID	**Client Name**	**DOS From**	**DOS To**	**Procedure Code**	**Units**	**Fund**	**Charge**	**Authorization Number**	**DOB**	**Sex**

Business Psychology Associates State of Idaho Substance Abuse Contract Recovery Support Services Alternative Billing Form

Instructions

Facility/Provider: _____ Submission Date: _____ Page # _____

BPA Client ID	Client Name	DOS From	DOS To	Procedure Code	Units	Fund	Charge	Authorization Number	DOB	Sex
123456	Seymour Sample	11/01/05	11/07/05	H0044	7	ATR	80.50	20050000001	02/01/1984	M
123457	Jane D. Example	11/25/05	11/25/05	H0006	4	ATR	45.00	20050000002	07/27/1980	F

This is Client ID assigned by BPA

The client name should be exactly as given from the BPA system, if the name is misspelled in the BPA system, enter the correct spelling followed by the letters sp in parentheses (sp)

Jane Doe (sp_

Starting date of Service

Ending date of Service

Authorized & contracted procedure code

Number of units – type of unit must match fee

State contract funding source

Provider billed amount

BPA Authorization /voucher number

Client Date of Birth MM/DD/YYYY

Client Gender M/F

APPROVED OMB-0938-0008

PLEASE DO NOT STAPLE IN THIS AREA

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ☐ NO ☐

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. ____ . __ 3. ____ . __

2. ____ . __ 4. ____ . __

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1										
2										
3										
4										
5										
6										

25. FEDERAL TAX I.D. NUMBER SSN EIN ☐ ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

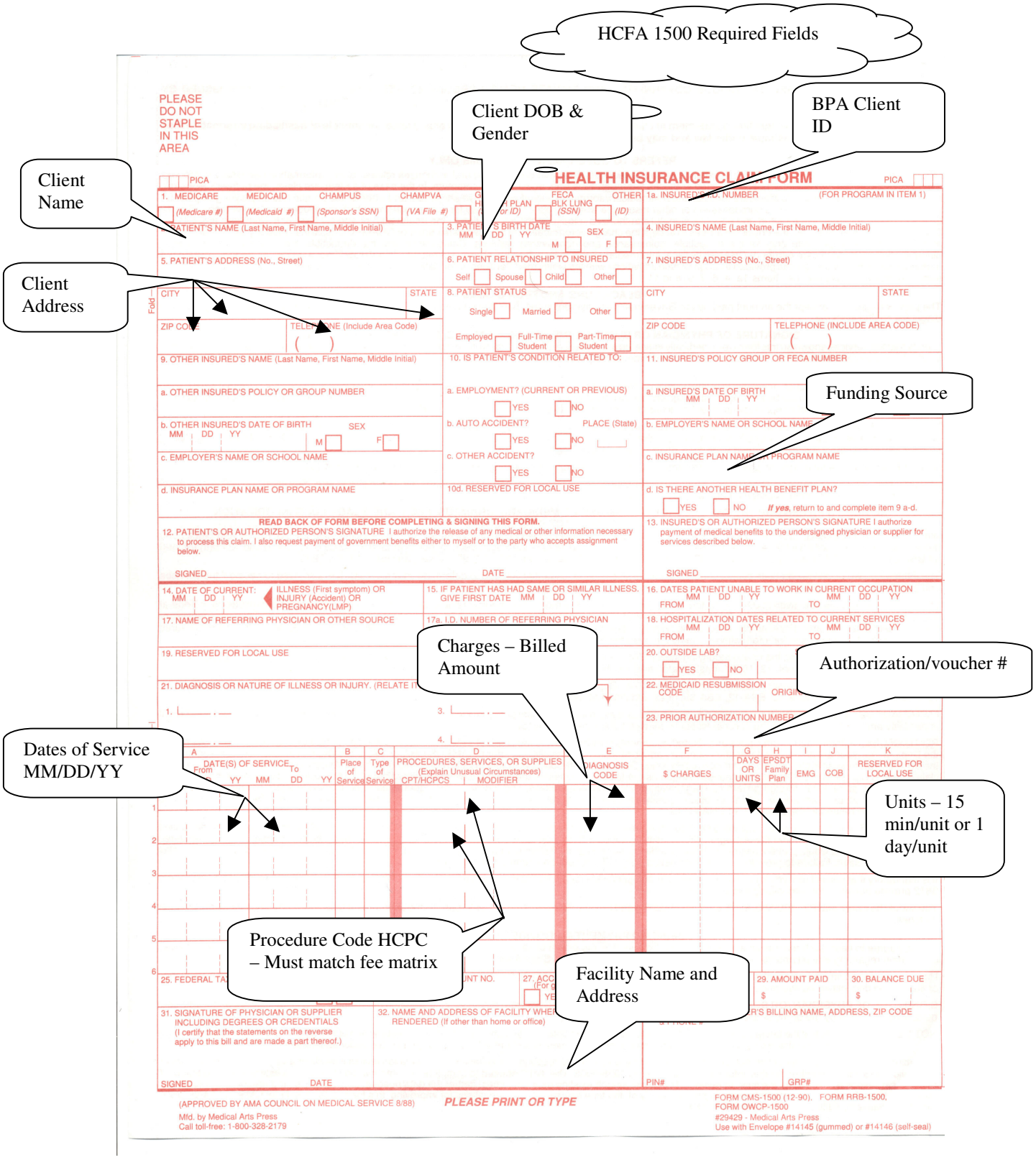
PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

Mfd. by Medical Arts Press
Call toll-free: 1-800-328-2179

PLEASE PRINT OR TYPE

FORM CMS-1500 (12-90). FORM RRB-1500, FORM OWCP-1500
#29429 - Medical Arts Press
Use with Envelope #14145 (gummed) or #14146 (self-seal)


HCFA 1500 Required Fields
PLEASE DO NOT STAPLE IN THIS AREA
Client DOB & Gender
BPA Client ID
Client Name
Client Address
HEALTH INSURANCE CLAIM FORM
PICA
Funding Source
Charges – Billed Amount
Authorization/voucher #
Dates of Service MM/DD/YY
Units – 15 min/unit or 1 day/unit
Procedure Code HCPC – Must match fee matrix
Facility Name and Address
PLEASE PRINT OR TYPE

IMA PROVIDER
123 Any Street

Anywhere, ID 12345- US

Detailed Remittance Advice

Check Number: 4
Check Date: 06/24/2004
Check Total: $49.00

Authorization Number	Insurer	Policy #	Plan	Group
Claim Number	Provider Claim #	Level of Care		Provider's Patient ID #

Service Dates	CPT Code	Claimed Amount	Denied Amount	Co-Pay Amount	Deductible Amount	Amount Paid	Reason
Client Name: Test, Test			SSN: 111-11-1100	Reference #:970000000005		Birth Date: 01/01/1982	Sex: F
Auth # 200400149246	State of Idaho		11111110000	IBHP FY 03		Health & Welfare	
Claim # 200400239424			Level of Care: MH - OP - Individual Therapy - 45-50 min				
07/05/2003	90806	$70.00	$1.00	$20.00		$49.00	62

Business Psychology Associates
300 E. Mallard, Suite 350
Boise, Idaho 83706

62 Exceeded Contracted Amount May not bill to Member

IMA PROVIDER
123 Any Street

Anywhere, ID 12345- US

Detailed Remittance Advice

Check Number: 4
Check Date: 06/24/2004
Check Total: $49.00

Authorization Number	Insurer	Policy #	Plan	Group
Claim Number	Provider Claim #	Level of Care		Provider's Patient ID #

Service Dates	CPT Code	Claimed Amount	Denied Amount	Co-Pay Amount	Deductible Amount	Amount Paid	Reason

Client Name: Test, Test — SSN: 111-11-1100 — Reference #:970000000005 — Birth Date: 01/01/1982 — Sex: F

Auth # 200400149246 — State of Idaho — 11111110000 — IBHP FY 03 — Health & Welfare

Claim # 200400239424

Level of Care: MH - OP - Individual Therapy - 45-50 min

07/05/2003	90806	$70.00	$1.00	$20.00		$49.00	62

Date of Service

Procedure code (HCPC)

Insurer

Billed Amount

Policy #

RSS Service

Denied amount

Plan

Paid Amount (equals) Billed amt minus denied amt minus copay amt.

Denial code

Business Psychology Associates
300 E. Mallard, Suite 350
Boise, Idaho 83706

62 Exceeded Contracted Amount May not bill to Member

BPA Denial/Adjustments Reasons Matrix

HIPAA Adjustment (Denial) Reason	Resubmit	Appeal	Code	BPA Denial Letter Language
The procedure code is inconsistent with the provider type/specialty (taxonomy).		X	89	Procedure code is inconsistent with provider type
Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.	X		123	Authorization # missing or inapplicable
Claim/service lacks information which is needed for adjudication.	X		90	Claim lacks information needed for adjudication
Payment adjusted because requested information was not provided or was insufficient/incomplete.	X		124	Information incomplete
Payment adjusted because charges have been paid by another payer.		X	91	Charges have been paid by another payer
Expenses incurred prior to coverage.		X	92	Expenses incurred prior to coverage.
Expenses incurred after coverage terminated.		X	93	Expenses incurred after coverage terminated.
The time limit for filing has expired.		X	94	The time limit for filing has expired.
Claim denied as patient cannot be identified as our insured.	X		95	Patient cannot be identified as our insured/covered
Our records indicate that this dependent is not an eligible dependent as defined.		X	96	Not an eligible dependent as defined
Lifetime benefit maximum has been reached.		X	97	Lifetime benefit maximum has been reached.
Services not provided or authorized by designated (network/primary care) providers.		X	125	Out of network provider
Charges do not meet qualifications for emergent/urgent care.		X	98	Charges do not meet criteria for emergent/urgent care
Charges exceed our fee schedule or maximum allowable amount.		X	62	Charges exceed fee schedule/mazimum allowable amount
Charges exceed your contracted/ legislated fee arrangement.		X	99	Charges exceed your contracted fee arangement
This (these) diagnosis(es) is (are) not covered, missing, or are invalid.	X		100	Diagnosis(es) are not covered, missing, or invalid
These are non-covered services because this is not deemed a `medical necessity' by the payer.		X	126	Not medical necessity
The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed.		X	101	Provider not eligible for service billed
Payment adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.		X	102	Rendered in an invalid place of service
Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.	X		103	Absence of, or exceeded, pre-authorization
Non-Covered days/Room charge adjustment.		X	104	Non-Covered days/Room charge adjustment.
Professional fees removed from charges.		X	105	Professional fees removed from charges.
Processed in Excess of charges.			106	Processed in Excess of charges.
Benefits adjusted. Plan procedures not followed.		X	107	Benefits adjusted. Plan procedures not followed.
Non-covered charge(s).		X	108	Non-covered charge(s).
Payment made to patient/insured/responsible party.		X	109	Payment made to patient/insured/responsible party.
Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.		X	110	Not covered by this payer, submit to correct payer
Billing date predates service date.		X	111	Billing date predates service date.
Benefit maximum for this time period or occurrence has been reached.		X	67	Benefit maximum has been reached for time period
Psychiatric reduction.		X	112	Psychiatric reduction.
Payment adjusted due to a submission/billing error(s).	X		113	Payment adjusted due to a submission/billing error
Claim/service denied. Appeal procedures not followed or time limits not met.		X	114	Appeal process not followed or time limits not met
Patient/Insured health identification number and name do not match.	X		127	Patient ID# & name do not match
Claim adjustment because the claim spans eligible and ineligible periods of coverage.		X	115	Spans eligible & ineligible periods of coverage
Claim/service rejected at this time because information from another provider was not provided or was insufficient/incomplete.	X		128	Other provider info incomplete
Payment adjusted because the payer deems the information submitted does not support this level of service.		X	116	Information does not support this level of service
Payment adjusted because the payer deems the information submitted does not support this many services.		X	117	Information does not support this many services
Payment adjusted because the payer deems the information submitted does not support this length of service.		X	118	Information does not support this service length
This claim is denied because the patient refused the service/procedure.		X	119	Claim denied as patient refused service/procedure
Non-covered visits.		X	120	Non-covered visits.
Services not documented in patients' medical records.		X	121	Services not documented in clients medical records
Previously paid. Payment for this claim/service may have been provided in a previous payment.		X	65	Previously considered
Payment denied because only one visit or consultation per physician per day is covered.		X	122	Only one visit per physician per day is covered

BPA

Appeal and Complaint Process
For the State of Idaho Substance Abuse Contract

Appeal: A written request by a provider, or a member or member representative for reconsideration of any adverse benefit determination whether it involves a pre-service or post-service denial, reduction, or termination of benefits.

Pre-Service Appeal: An appeal that must be decided before a member is qualified to receive benefits that the member has requested from BPA. Typically, an appeal of the withholding of authorization for services. An example is:

Screening Procedure:

1. Client calls in for screening.
2. He/She is determined ineligible either financially or clinically.
3. If the provider or other personal representative has other information that may change the determination, please call the Care Manager to discuss. BPA prefers to resolve this issue over the phone.

Concurrent Services Appeal:

Concurrent Review Procedure:

1. Provider calls BPA and speaks to a Care Manager about obtaining additional units over the telephone.
2. The Care Manager does a Risk Factor Review with the provider over the telephone.
3. If the Care Manager denies the care from the information obtained from the Risk Factor Review the following options are available.
    a) Provider is given the opportunity to appeal the denial over the telephone. The provider can verbally give more information at that time or call back with more information to add to the Risk Factor Review, however treatment units will not be backdated.
    b) If the additional information continues not to meet ASAM criteria the provider may submit a written appeal on the Appeal form and fax or mail to the Quality Assurance Department, 300 E. Mallard Dr. Suite 350 Boise, ID 83706. The fax number is 208-947-4392.
    This will be decided within 15 calendar days.

Post-Service Appeal: A written appeal that involves only the payment of or reimbursements for the cost for care already provided. If a claim has been denied for services rendered and the provider disagrees with or does not understand the denial, the provider should submit an appeal form, included in this packet. The appeal will be considered and adjudicated within 30 days. BPA will review the appeal letter and previous clinical submitted on the client's behalf. We will not review any new clinical information that may be submitted for the substance abuse contract.

Expedited Appeals for Urgent/Emergent Care: Any pre-service claim involving an urgent/emergent need for treatment due to the potential risk of:

1. Seriously jeopardizing the life or health of the member or the ability of the member to regain maximum function; or

2. Subjecting the member to severe pain that cannot be adequately managed without the treatment that is the subject of the claim, in the opinion of a physician with the knowledge of the member's condition.

If additional information is needed to determine benefits for an expedited appeal for urgent care, BPA will notify the member, provider and/or his/her representative within 24 hours of the urgent care appeal, and provide no less than 48 hours for the member or provider to supply additional information.

Note: BPA will make a benefit determination within the mandated 72-hour timeframe regardless of whether or not the requested additional information is received.

First and Second Level Review: These levels of appeal will be determined by either another Care Manager that was not involved in the initial denial and/or by BPA's Medical or Clinical Director. Once an appeal has gone through both levels of internal appeals at BPA the provider will be given the procedure to facilitate a third level review with the Department of Health and Welfare.

Third Level Review: Review of an adverse benefit determination made by BPA following a Second Level Appeal will be reviewed by the Department of Health and Welfare. Send the appeal to:

Department of Health and Welfare
Attn: Bethany Gadzinski
PO Box 83720
Boise, ID 83720

Complaints:

If a provider or client has concerns about an issue that is not specifically related to the pre-concurrent or post-treatment descriptions above, they should file a complaint. Please utilize the complaint form (included in the packet).

All appeals and complaints can either be mailed or faxed to the below address.

BPA
Quality Assurance Department
380 E. Parkcenter Blvd., Suite 300
Boise, ID 83706
208-947-4392 fax

BPA
Appeal Submission Form

Date: _____

Appeal Initiated by: Client ☐ Provider ☐ Parent ☐ Other _____

Mark the type of appeal: ☐ Urgent/Emergent ☐ Routine

Client Name: _____ Name of Plan: _____

BPA Client ID #: _____ Provider Name: _____

Level of Care: _____ Dates of Service Denied: _____

Appellants Name and Address: _____

_____

Please attach your appeal letter to this document. If you choose to take advantage of both of BPA's internal appeals process, please make sure you attach this document both times. It will help us track where your appeal is in the process.

Level I Appeal Determination (circle one): Approved Denied

Reason for Denial: _____

_____

_____

Reviewers Name (print): _____

Reviewers Signature: _____

Level II Appeal Determination (circle one): Approved Denied

Reason for Denial: _____

_____

_____

Reviewers Name (print): _____

Reviewers Signature: _____

380 E. Parkcenter Blvd.
Suite 300
Boise, ID 83706
1-800-211-9477
208-344-7430 fax

BPA
Complaint Form

Date: _____

Complainant Name: _____

Complaint Initiated by: Client Provider Parent Broker HR Representative
 Other _____

Client's name (if the complaint is related to a client/employee): _____

Would you like a call back from BPA in regards to this complaint? If yes, please list your phone number.
_____

Is a message OK at this number? _____

Please put a description of the complaint below along with a possible course of action:

380 E. Parkcenter Blvd.
Suite 300
Boise, ID 83706
1-800-211-9477
208-344-7430 fax